STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395397	A. BLDG: 00 B. WING:	05/02/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
KINGSTON REHABILITATION AND NURSING CENTER STATE LICENSE NUMBER: **900102**	**200 SECOND AVENUE** **KINGSTON, PA 18704**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0000	INITIAL COMMENT	F 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE: (X6) DATE:

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

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F 0000	Continued from page 1 Based on a revisit and abbreviated complaint survey completed on May 2, 2023, it was determined that Kingston Rehabilitation and Nursing Center corrected the federal deficiency cited during the survey of April 4, 2023, under the requirements of 42 CFR Part 483 Subpart B bu failed to correct the deficiencies cited during the survey of March 10, 2023, and continued to be out of compliance with the following requirements of 42 CFR Part 483 Subpart B Requirements for Long Term Care and the 28 PA Code Commonwealth of Pennsylvania Long Term Care Licensure Regulations.	F 0000		
F 0557 SS=D		F 0557		

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F 0557 SS=D	Continued from page 2 483.10(e)(2) Respect, Dignity/Right to have Prsnl Property §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. This REQUIREMENT is not met as evidenced by:	F 0557	Resident C1 was assisted with removal of facial hair and the care plan was updated to reflect facial hair removal preference. Current facility residents will be reviewed to verify if assistance is needed to remove facial hair(if preferred) Identified resident care plans will be updated to reflect changes if needed. Staff Educator/designee will complete an education with current nursing staff to review facial hair removal offering. Random observation audits will be completed weekly by DON/designee for resident facial hair removal. Results will be reviewed by the QAPI committee to determine if additional audits or education is needed.	Completion Date: **05/15/2023** Status: **APPROVED** Date: **05/11/2023**

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F 0557 SS=D	Continued from page 3 Based on observation, clinical record review and resident and staff interview, it was determined that the facility failed to provide care in a manner respectful of each resident's personal dignity by failing to ensure the resident maintained a dignified personal appearance for one resident out of 17 sampled (Resident C1). Findings included Clinical record review revealed that Resident C1 was admitted to the facility on January 18, 2023, with a diagnosis of breast cancer. An observation conducted on May 2, 2023 at 10 AM revealed Resident C1 was in her room, lying in bed. A nurse aide had just completed the resident's morning care.	F 0557		

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F 0557 SS=D	Continued from page 4 An interview conducted at the time of the observation revealed that Resident C1 stated that she had a dentist appointment the day before and had dental work completed. The resident stated that she was very embarrased at the appointment because of the large amount of facial hair on her face. The resident stated that nursing staff had not removed her facial hair for approximately 10 days and significant regrowth was present. The resident was upset that nursing staff did not remove her facial hair prior to attending the dental appointment and that nursing had not yet removed her facial hair as of the time of this interview. A review of the resident's care plan for activities of daily living revealed that the resident's care plan did not address the	F 0557		

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F 0557 SS=D	Continued from page 5 resident's need for assistance with facial hair removal and the resident's preference for hair removal to remain free of facial hair. During an interview May 2, 2023 at approximately 1 P.M., the Nursing Home Administrator confirmed that the facility failed to ensure the personal dignity for this resident by failing to consistently provide services necessary to maintain a dignified personal appearance. 28 Pa. Code 201.19 (j) Resident rights 28 Pa Code 201.18(e)(1) Management	F 0557		
F 0585 SS=D		F 0585		

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F 0585 SS=D	Continued from page 6 483.10(j)(1)-(4) Grievances §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance	F 0585	Resident C1 grievance was written up to address her verbal concern. The facility will conduct an ad hoc resident council meeting to allow residents to verbally express concerns they may have. A grievance will be completed on their behalf post meeting to address and resolve any concerns discussed. Staff Educator/designee will complete an education to the IDT and nursing staff on completing grievances made verbally by a resident so timely resolution will occur. Random resident interviews will be completed by IDT team during non-clinical rounds to determine if there are unresolved verbally reported resident concerns that need follow up. Grievances will be completed and addressed as they occur with resolution follow up per grievance policy. The results will be reviewed by the QAPI committee to determine if additional audits are	Completion Date: **05/15/2023** Status: **APPROVED** Date: **05/15/2023**

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F 0585 SS=D	Continued from page 7 can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the	F 0585	needed or education.	

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F 0585 SS=D	Continued from page 8 date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by:	F 0585		

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F 0585 SS=D	Continued from page 9 Based on review of select facility policy, resident and staff interviews it was determined that the facility failed to demonstrate sufficient efforts to promote prompt resolution of an oral grievance for one of 17 sampled residents (Resident C1). Findings include: The facility's grievance policy, last reviewed by the facility January 2023, revealed that the purpose of the grievance program was to promote an environment and culture open to feedback positive and/or negative from residents, family members, employees, physicians, and any other visitors. All grievances whether filed with staff or the grievance officer will be completed by the following procedure: upon receipt of the grievance, the	F 0585		

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F 0585 SS=D	Continued from page 10 grievance officer will designate an administrative staff member to investigate the concern, the grievance officer will maintain the grievance log, concerns related to alleged abuse, neglect, exploitation, or misappropriation of funds or belongings will be handled according to the state and federal guidelines. Immediate actions will be taken that are necessary to prevent further potential violations of any resident right. Clinical record review revealed that Resident C1 was admitted to the facility on January 18, 2023 with diagnoses to include, breast cancer and morbid obesity. A review of a significant change MDS assessment dated January 24, 2023 (Minimum Data Set - a federally mandated	F 0585		

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F 0585 SS=D	Continued from page 11 standardized assessment conducted at specific intervals to plan resident care) revealed that Resident C1 was cognitively intact and required maximum assistance for activities of daily living, including bed mobility, transfers and toileting. A review of the resident's care plan dated September 20, 2022, for the problem/need of activities of daily living (ADL) deficit revealed that Resident C1 required assistance of two staff for bed mobility and toileting. The resident currently used a bed pan when in bed for toileting needs according to the resident's care plan. During an interview May 2, 2023 at 10 AM, Resident C1 stated that she waits up to 45 minutes for staff assistance when she rings the call bell requesting care, including toileting. She stated that	F 0585		

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F 0585 SS=D	Continued from page 12 because she requires assistance of two staff for toileting, and because of the facility's staffing levels, she sometimes has to wait a long time for staff to assist her onto the bed pan and off the bed pan. Resident C1 stated that she has voiced her concerns regarding the long waits for staff assistance both on and off the bed pan to nursing staff, but to date, her complaint has not been resolved and the long waits for staff assistance with her toileting needs have continued. There was no evidence at the time of the survey ending May 2, 2023, that the facility had addressed Resident C1's verbal complaint regarding long waits for assistance to use the bed pan and then to be removed from the bed pan. Interview with the Nursing Home	F 0585		

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F 0585 SS=D	Continued from page 13 Administrator on May 2, 2023, at approximately 1:00 PM confirmed that there was no evidence that Resident C1's oral grievance regarding untimely staff assistance to meet her toileting needs were timely and adequately addressed by the facility. 28 Pa Code 201.29 (i) Resident rights 28 Pa. Code 201.18(e)(1) Management	F 0585		
F 0656 SS=D		F 0656		

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F 0656 SS=D	Continued from page 14 483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future	F 0656	Resident B1 care plan was updated at the time of survey to include maintaining skin integrity, psychotropic drug use and pain management. Current facility residents with identified needs of maintaining skin integrity, psychotropic drug use and pain management will have a care plans review completed and updated if needed. Regional MDS coordinator will conduct an education with the MDS and IDT on the development and implementation of comprehensive person-centered care plans. Random audits will be completed with the MDS schedule for new admissions, quarterly, significant changes and annual assessments. The results will be reviewed by the QAPI committee to determine if additional audits are needed or education.	Completion Date: **05/15/2023** Status: **APPROVED** Date: **05/11/2023**

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F 0656 SS=D	Continued from page 15 discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by:	F 0656		

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F 0656 SS=D	Continued from page 16 Based on a review of clinical records and staff interview, it was determined that the facility failed to develop and implement a comprehensive person-centered care plan to meet a resident's needs for maintaining skin integrity, psychoactive drug use and pain management for one resident out of 17 sampled (Resident B1). Findings include: A review of the clinical record revealed that Resident B1 was admitted to the facility on February 1, 2023, with diagnoses that included morbid obesity due to excessive calories, Major Depressive Disorder, malignant neoplasm of rectum, bone, and intrathoracic lymph nodes.	F 0656		

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	395397	A. BLDG: __00_____ B. WING: _____	05/02/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
KINGSTON REHABILITATION AND NURSING CENTER STATE LICENSE NUMBER: 900102	200 SECOND AVENUE KINGSTON, PA 18704

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F 0656 SS=D	Continued from page 17 A review of Resident B1's Admission Minimum Data Set (MDS-periodic assessment of care needs) dated February 8, 2023, indicated the Care Area Assessments triggered and were to proceed with care planning included pressure ulcers, psychotropic drug use and pain. The resident's MDS assessment also noted that the resident had moisture associate skin disorder. A review of Resident B1 's current comprehensive plan of care conducted on May 2, 2023 at approximately 9:00 a.m., revealed that the resident's care plan failed to identify the interventions planned to meet the resident's needs related to moisture associated skin disorder, psychotropic drug use, and pain. Interview with the Registered Nurse	F 0656		

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F 0656 SS=D	Continued from page 18 Assessment Coordinator on May 2,2023 at approximately 2:30 PM confirmed that the facility failed to proceed with care planning for each area triggered as identified on the CAA and the resident's comprehensive care plan was not fully developed. 28 Pa Code 211.11(d) Resident care plan. 28 Pa Code 211.12 (c)(d)(3)(5) Nursing Services.	F 0656		
F 0684 SS=E		F 0684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0684 SS=E	Continued from page 19 483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by:	F 0684	The facility cannot retroactively correct the deficient practice of ensuring consistent physician ordered treatment was completed, as identified on the grievance lodged by the Resident Representative for Resident A4 on April 22, 2023. Current facility residents with prescribed wound vac treatments will be reviewed to ensure wound vac placement and function are being monitored. Staff educator / designee will complete an education for Licensed Nurses for wound vac placement and function monitoring. DON / designee will conduct random weekly audit of wound vac treatments to verify placement/function weekly x 4 weeks then weekly x 2 weeks than monthly times 1. The results will be reviewed by the QAPI committee to determine if additional audits are needed or education.	Completion Date: **05/15/2023** Status: **APPROVED** Date: **05/11/2023**

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F 0684 SS=E	Continued from page 20 Based on a review of clinical records and grievances lodged with the facility and staff interviews it was determined that the facility failed to provide care, consistent with professional standards of practice, by failing to demonstrate consistent monitoring of the use of a therapeutic device, a wound vac, (therapeutic technique using a suction pump, tubing and dressing to remove excess exudate [fluid that leaks out of blood vessels into nearby tissues, pus] and promote healing) in the resident's wound care for one resident out of 17 sampled (Resident A4). Findings included: A review of the clinical record revealed that Resident A4 was admitted to the facility on January 26, 2023, with diagnoses to include end-stage kidney	F 0684		

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	395397	A. BLDG: 00 B. WING:	05/02/2023

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F 0684 SS=E	Continued from page 21 disease with dependence on kidney dialysis, heart disease, and diabetes. The resident was readmitted to the facility April 4, 2023, after hospitalization for a non-healing wound of right outer thigh. A physician order dated April 5, 2023, was noted for wound vac therapy to the resident's right outer thigh 3 times a week. The wound vac dressing was to be changed each Monday, Wednesday, and Friday. The physician order also noted that staff were to check the placement and function of the wound vac on the right thigh each shift. Resident A4's physician orders also noted that the resident was scheduled for dialysis every Monday, Wednesday, and Friday, at 3 PM.	F 0684		

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F 0684 SS=E	Continued from page 22 Review of grievance dated April 22, 2023, revealed that Resident A4's daughter/ responsible party, expressed a complaint that her father's wound vac on his right leg was not in consistently in use as ordered. According to the resident's daughter "every time he comes back from dialysis, the next day (Tuesday, Thursday, and Saturday) I find the vac is not plugged in or even turned on." The grievance also noted that the resident's daughter noticed a small amount of bleeding at the site of the resident's suprapubic (a tube inserted into the bladder through a small whole in the belly) catheter site and questioned if the area should be covered. The grievance further detailed that, Employee 9, an LPN, licensed practical nurse, investigated the daughter's concern. The findings indicated that a physician order was obtained to apply a "drainage	F 0684		

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F 0684 SS=E	Continued from page 23 sponge" to the suprapubic catheter site daily and education. The facility noted that that education was provided to two nurses, Employee 1 and Employee 2, on April 24, 2023, via the telephone. The educational content provided was verbal instruction to "follow MD orders, wound vac to be checked Q (every) shift for function and placement." Review of Resident A4's Treatment Administration Record (TAR) dated April 2023, revealed that there were 8 potential days from April 4, 2023, through April 24, 2023, that met the criteria noted in the grievance (Tuesdays, Thursdays and Saturdays after dialysis) on which the resident's wound vac may not have been plugged in or turned on as ordered as reportedly observed by the resident's	F 0684		

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F 0684 SS=E	Continued from page 24 daughter. However, the facility's response to the grievance was to verbally educate only two nurses, Employee 1 and 2. There was no evidence that the facility conducted observations of the wound vac for proper functioning and consistent use as ordered by the physician. There was no evidence that the facility had provided education to all applicable licensed and professional nursing staff that provided care to Resident A4 from April 4, 2023 through April 22, 2023 to ensure staff knowledge and awareness of the resident's use of the wound vac. The facility failed to demonstrate that Resident A4 received consistent physician ordered treatment and care to promote wound healing of his right thigh wound.	F 0684		

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F 0684 SS=E	Continued from page 25 28 Pa. Code 211.12 (a)(c)(d)(1)(5) Nursing services 28 Pa. Code 211.5 (g)(h) Clinical records	F 0684		

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H 0010	35 P. S. § 448.809b Photo Id Reg Law amended July 11, 2022 Act 79 2022 HB 2604 (1) The photo identification tag shall include a recent photograph of the employee, the employee's first name, the employee's title and the name of [the health care facility or employment agency.] any of the following: (i) The health care facility. (ii) The health system. (iii) The employment agency. (iv) The fictitious name of an entity under subparagraph (i), (ii) or (iii) which is registered with the Department of State under 54 Pa.C.S. Ch. 3 (relating to fictitious names) or a successor statute. (2) The title of the employee shall be as large as possible in block type and shall occupy a one-half inch tall strip as close as practicable to the bottom edge of the badge. (3) Titles shall be as follows: (i) A Medical Doctor shall have the title "Physician." (ii) A Doctor of Osteopathy shall have the title "Physician." (iii) A Registered Nurse shall have the title "Registered Nurse." (iv) A Licensed Practical Nurse shall have the title "Licensed Practical Nurse." (v) All other titles shall be determined by the department. Abbreviated titles may be used when the title indicates licensure or certification by a Commonwealth agency.	H 0010	Employee 3,4,5,6,7 and 8 had photo Id's completed. HR / designee will review employee list to determine if badges were completed for current employees. All agencies we use will be notified that their employees must have Id badges when they come to facility to work. A sign will be posted at the time clock that staff must have Id photo before starting work. If they do not have one or forgot to bring it to work, they must see the HR Director or Supervisor to get a temporary Id badge. Random audits will be completed weekly to assure compliance. The results will be reviewed by the QAPI committee to determine if additional audits are needed or education.	Completion Date: **05/15/2023** Status: **APPROVED** Date: **05/11/2023**

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE:	(X6) DATE:

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H 0010	Continued from page 1 (4)A notation, marker or indicator included on an identification badge that differentiates employees with the same first name is considered acceptable in lieu of displaying an employee's last name. This REGULATION is not met as evidenced by:	H 0010		

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H 0010	Continued from page 2 Based on observations and staff interview, it was determined that the facility failed to ensure that all facility employees had an identification tag to include a recent photograph, the employees first name and title including Employees 3, 4, 5, 6, 7, and 8. Findings include: Observations made on the day of the survey, May 2, 2023, revealed that multiple facility employees did not have a picture identification tag visible on the employee. Observation on March 2, 2023 at approximately 11 A.M. Employees 3 (agency nurse aide), Employee 4 (nurse aide), Employee 5 (floor tech), Employee 6 (nurse aide), Employee 7(housekeeping)	H 0010		

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H 0010	Continued from page 3 and Employee 8 (housekeeping) were observed with tape on which their individual names were written and taped to their clothing. During an interview at the time of the observation, Employees 3, 4, 5 ,6, 7, and 8 each stated that the facility had not supplied them with an identification tag and they were all told by their supervisors to place their names on a piece of tape and wear it as an identification tag. During an interview on March 2, 2023, the Nursing Home Administrator was not aware that staff in the facility currently did not have photo identification name tags.	H 0010		

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H 0010	Continued from page 4	H 0010		

Certified End Page

KINGSTON REHABILITATION AND NURSING CENTER

STATE LICENSE NUMBER: 900102

SURVEY EXIT DATE: 05/02/2023

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey

Jeane Parisi
Deputy Secretary for Quality Assurance

Debra L. Bogen, MD, FAAP
Acting Secretary of Health

pennsylvania
DEPARTMENT OF HEALTH

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

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